MIHP Implementation WorkGroup

July 18, 2007

Present: Alethia Carr, Ingrid Davis, Paulette Dobynes Dunbar, Jean Egan, Brenda Fink, Mary Ludtke, Deb Marciniak, Gail Maurer, Betty Tableman.

Phone: Dianna Baker, Mark Bertler, Sheila Embry, Pat Fralick, Sue Gough, Diane Revitte, Carolynn Rowland, Peggy Vandermeulen, Vanessa Winborne, Betty Yancey.

Tasks

1. Deb Marciniak will forward the web site address for getting info on the Assuring Better Child Health and Development (ABCD) Initiative.
2. WG members will send comments on the MIHP Recommended Stratification Criteria and Interventions: Behaviors Health/Depression, Draft 07-12-07, to Deb by Aug 1.

MIHP Progress Updates

The WG systematically reviewed *MIHP Progress Updates at a Glance, 07-12-07*. The following items were discussed:

Integrated Screener. Pat Fralick has requested that the integrated screener be converted for electronic data entry or providers who have been using the paper version will have to take a step backward when they are required to begin entering prenatal risk identifier data electronically on Oct. 1. This request has been forwarded to Sue Moran to see if she can identify funds to contract with a DIT programmer to do this. Mark Bertler asked for a copy of this memo to take to Teri Takai, DIT Director, and Pat suggested talking to Jim Butler about funding. Brenda said that DCH wants to convert the integrated screener for electronic data entry, and will move forward with this when funds are identified. Five MIHP providers, along with Jean and Ingrid, have reviewed the electronic screener and made very helpful suggestions. It's not perfect, but it's a very good start. The Data System WG will decide if DCH will approve each individual to sign-on to access the database or if providers will be responsible for this.

Infant Screener Rollout. Gail Maurer said no date has been set to rollout the infant screener. Right now the push is to get the prenatal screener out the door, then the integrated screener, then the infant screener.

Interconceptual Care Domain. Peggy Vandermeulen and Sue Gough offered to help Cheryl Lauber develop the interconceptual care domain for the infant screener. The plan is to base the MIHP interventions on the CDC recommendations, the PPOR approach and IM Coalition efforts. Sue said that she is on the Detroit and Macomb IM Task Forces and is often asked how MIHP is addressing the interconceptual period.

Reimbursement WG. An internal meeting of the Reimbursement WG has been scheduled. This internal group will be expanded to include providers. Providers who wish to volunteer must understand current reimbursement relative to actual costs and be willing to share their reimbursement data with DCH. It's important to have a few financial officers or program people who understand the financial picture. MALPH approved Linda Yaroch as their rep. Sue Gough said she would volunteer as a private provider but would need assurance that proprietary data won't be published. Brenda said info would be shared in the course of a discussion and not in a FOIable document.

ABCD Project. Michigan is one of 20 states/territories selected to participate in the ABCD (Assuring Better Child Health and Development) Screening Academy, an initiative supported by The Commonwealth Fund. http://www.commonwealthfund.org/topics/topics_show.htm?doc_id=429345 During the 15-month project, the 20 teams are receiving TA to integrate valid and standardized child development tools into preventive health care practice. Use of these instruments has been found to increase identification of young children with or at risk of cognitive, social, and emotional developmental problems, thereby increasing access to early intervention services. Each team is led by the state's Medicaid program and includes other public agencies, along with child health physician associations, other clinicians, and nonprofit organizations. Physician champions are critical to this effort.

Brenda said that Michigan is focusing initially on 0-5 and that MIHP's role in coordinating with the medical home will be emphasized. MIHP built the ASQ and ASQ:SE into our infant screener. In ABCD, physicians get a choice of screeners but in other states, 95% of them chose the ASQ. It may be possible to form a multi-state collaborative to purchase the ASQ. If it gets to the point where all physicians are using the ASQ, we may not need to use it in MIHP, but we have a long way to go before then.

ABCD is more than screening – it also involves coordinating referrals to the programs that kids need, especially Early On for 0-3. MIHP is required by Medicaid policy to refer to and coordinate with Early On. When Ingrid and Jean conduct program reviews, they will ask providers how they do this.

Mary Ludtke is coordinating a September meeting for the ABCD physicians and the Early On and MIHP staff from the communities where these physicians practice. Those of you who have an ABCD physician practicing in your community will be invited to this meeting. We hope to have Detroit as a pilot. We will promote medical home and coordination protocols within the Early On system. Vanessa Winborne said Early On is very excited to be part of this effort to support family practice physicians to use a uniform approach to screen for developmental delays. We will keep you informed about this.

The Michigan Chapter of AAP is participating in "Setting the Stage for Success: Implementation of Behavioral and Developmental Screening and Surveillance in Primary Care Practice", which also promotes implementation of standardized developmental screening throughout the medical community. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=381569

AAP came out with a statement that screening will start at 9 months - MIHP starts screening sooner.

MIHP Depression Interventions

The MIHP Perinatal Depression Workgroup (PDWG) spent over a year reviewing the literature, talking with depression experts, and surveying MIHP providers before making its recommendations. Their full report is on the MSU Institute for Health Care Studies web site. The PDWG may reconvene to write an application for SAMHSA funds to support a perinatal depression conference. The PDWG recommendations regarding MIHP depression interventions were originally discussed at our Jan 2007 Implementation WG meeting. At that time, Lynette, Mary and Deb were asked to detail them further. Today we are asking for your input on the next iteration dated 07-12-07.

Brenda noted that CMHSPs only serve women with severe mental illness. Therefore, MIHP providers need to encourage women with depression in Medicaid health plans to use their OP benefit (20 visits annually) and to encourage all women with depression to see their primary care physicians for an evaluation to determine if psychotropic medication is appropriate. Research indicating that psychotropics are safer for the baby than untreated maternal depression continues to mount. Brenda also noted that the majority of pregnant women are not in health plans, and that Medicaid coverage for many women ends two months post-delivery. She said that the hope is that CMS will approve the Michigan First waiver, which would mean that most women in MIHP would not lose their Medicaid two months after post-delivery, although we have no idea when the waiver would be approved.

Today, we are not going to discuss the recommendation that MIHP providers offer cognitive behavioral counseling/education (CBC) for women with moderate or severe depression who can't access mental health treatment services. This recommendation is on hold pending internal DCH discussions on scope of practice considerations, the feasibility of ratcheting CBC down from "therapy" to "education" for use in our case management model, and the likelihood that CMS will approve us to do this in light of Michigan's mental health carve-out.

Comments on the depression interventions included the following:

1. Would like to see the perinatal depression conference.
2. Education in low-risk group is good, but provider should monitor for depression more frequently than every 3 months. (This is an outside limit; providers certainly can do it more often.)
3. We currently don't have the ability to do this much monitoring. (Yes, but this will change.)
4. Some health plans do monthly depression monitoring over the phone. (We need to move as quickly as possible to least costly effective strategies.)
5. At all 3 risk levels, the provider is coordinating with the PCP and mental health specialist.

6. Why doesn't it say to refer infants with depressed moms to Early On and other services? (These are the interventions for the prenatal period – intent was that infants would be addressed in the postnatal interventions. However, since the WG wants one document covering both periods, we will: alert providers to pay special attention to infant once mom is experiencing depression; add interventions pertaining to the infant, e.g., "once baby is born, also use these interventions;" and specify Early On as a referral source).

Cathy Kothari, a PDWG member from the MSU Kalamazoo Center for Medical Studies (KCMS), reports that KCMS has received a grant from the BCBC Michigan Foundation to establish a comprehensive system for identifying and treating perinatal depression. She has asked permission to adapt the MIHP intervention framework (3 levels of intervention) and other PDWG recommendations for this project.

Tobacco Domain

Jean Egan explained that the Ottawa Health Dept. and Priority Health are piloting the tobacco interventions and care plan. She will provide training for the pilots on Aug. 2 via webinar (BREEZE software). The pilots will provide feedback at two points: initial impressions on Aug. 24 and final feedback on Oct. 26. In their initial case reviews, the pilots weren't able to identify many women who smoke a pack a day or more, so it may be difficult to test the high-risk interventions.

Pat Fralick said that we'll have this protocol for high-risk women, but won't be able to use it because they won't admit to smoking that many cigarettes. If we had adequate time to work with women on this, we could reduce costs related to smoking. Brenda said we know that many women smoke more than they admit to, but all we can do is build trust. Pat said that this presupposes that we will have the time to visit with these women. MIHP providers will be encouraged to contact women over the phone, but programs are finding that women run out of cell-phone minutes, especially at the end of the month, and Pat is concerned about the emphasis on phone contact across the board. So, could any smoker who is ready to change be offered the higher level of intervention? Brenda noted that most smokers will have other risks. Jean said that the screeners they've looked at so far showed that none of the women scored high-risk on only one domain – most scored high-risk on two domains. As the electronic data comes in, we'll learn how many women are identified at each risk level and be able to determine if risk-level scores match case records. Diana Baker noted that the MFMP is using the algorithm to score all of the 2006 screeners for Kent Co. right now.

Gail Maurer said that if a provider picks up info that suggests a woman is at higher risk than determined by the screener (e.g., sees a problematic parent /child interaction), the provider can document her professional judgment in the case record and intervene at a higher level. Sue Gough noted that if we base reimbursement on risk level, it will need to be done empirically.